h. Rural Hospitals With Sixty (60) Beds of Less

Effective for services on or after November 1, 1990, rural hospitals with sixty (60) beds or less who have a service municipality with a population of 20,000 or less shall be reimbursed for inpatient hospital services based on allowable costs as defined by Medicare principles of reimbursement. The TEFRA cost per discharge limitations shall not be applied to allowable inpatient program cost at these hospitals.

5. The methods of cost apportionment currently used in computing reimbursement to such hospitals under Title XVIII of the Act except that effective July 1, 1969:

The inpatient routine services costs for Medical Assistance recipients will be determined after the application of the Title XVIII method of apportionment and the calculation will exclude the applicable Title XVIII inpatient routine services charges or patient days, as well as Title XVIII inpatient routine services costs (including any nursing salary cost differential).

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B. Effective for dates of service on or after July 1, 1994, Medicaid reimbursement for inpatient hospital services in a non-state operated hospital will be made according to prospective per diem rates for various peer groups of hospitals/units.

Exception: Reimbursement for the following specialty units differs from the methodology in Item B. , and each is calculated using a unique methodology as described in the specified letter location under Section 1. Costs for these units are carved out of the costs for the general or specialty hospitals, and used to calculate rates specific to these units.

Hospital/Unit Type	Item Letter
Distinct Part Psychiatric Units	F
Transplant Units	G
Head Injury Neurological Rehab Care Units	H

1. Peer Groups

a. The five general hospital peer groups are:
(1) Major teaching hospitals
(2) Minor teaching hospitals
(3) Non-teaching hospitals with less than 58 beds
(4) Non-teaching hospitals with 58 through 138 beds
(5) Non-teaching hospitals with more than 138 beds

b. Separate peer group payment rates are established for each group of these specialty hospitals:
(1) Rehabilitation hospitals
(2) Long-term (ventilator) hospitals
(3) Children's hospitals

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c. Separate peer group payment rates are established for each group of resource-intensive inpatient services listed below. Costs for these units are carved out of the costs for the general or specialty hospitals listed above, and used to calculate rates specific to these units.

(1) Neonatal Intensive Care (NICU) Unit (3 levels)
(2) Pediatric Intensive Care (PICU) Unit (2 levels)
(3) Burn Care Unit

2. General Information About Calculation of Rates

Costs are proportionately allocated in cost reports filed by the provider to ensure that there is no duplication of costs to the hospital and its specialty unit(s).

Allowable costs are those unaudited reported costs which conform to the Medicare principles of reimbursement.

Swing bed days and costs are excluded from reported costs.

3. Base Cost

Cost for each component for each hospital that was enrolled as a Medicaid provider in 1991 is derived from that provider's allowable cost per day for that component from its filed cost report for the hospital's reporting period ending in calendar year 1991.

For hospitals that completed six months or more of operation and filed a cost report by June 30, 1994, component cost will be derived from the first cost report filed.

Hospitals not having completed six months or more of operations and not having filed a cost report by June 30, 1994 will receive the applicable peer group rates for SFY 1994/95 and subsequent years.

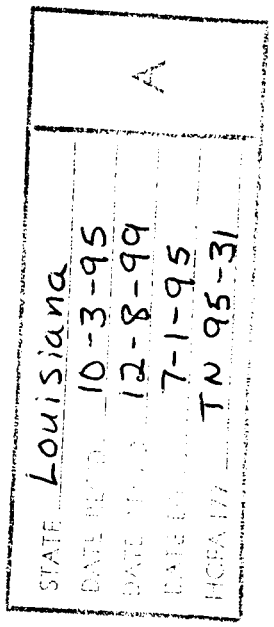
Hospitals beginning operations subsequent to FY 1991 (the base year) will be placed into the appropriate peer group. Change of ownership or acquisition of a different provider number by an operating, participating hospital does not result in a hospital becoming a new hospital. A hospital that existed but was not enrolled in the base year is considered a new hospital.

Base costs for hospitals or specialty units that change peer groups are derived from 1991 allowable cost per day for that component from its filed cost report for the hospital's reporting period ending in calendar year 1991.

4. Inflation Factor

The Data Resources Incorporated (DRI) Hospital Market Basket Index for non-PPS hospitals, Table 2 was used to inflate components.

Derivation of first year payment components. For hospitals enrolled as Medicaid providers in 1991, cost for each component (fixed capital costs, medical education costs, movable equipment costs, and operating costs) for each hospital is calculated based on each provider's allowable cost per day for that component from its filed cost report for the hospital's reporting period ending in calendar year 1991 inflated from the hospital's fiscal year midpoint of the base year (1991) to the midpoint of the implementation year (December 31, 1994) using the index from the fourth quarter percent movable average.



Hospitals that have completed six months or more of operation and have filed a cost report by June 30, 1994 have components trended forward from the midpoint of the hospital's first cost report year to the midpoint for the state fiscal year beginning July 1, 1994 (which is December 31, 1994) using the index from the fourth quarter percent movable average.

Calculation of subsequent year components. Medical education costs, movable equipment costs, and operating costs are inflated by applying the most recently published index available before the start of the next fiscal year (mid-April) to the most recent component cost for each hospital.

Recalculated rates resulting from application of inflation factors are effective for services provided on or after July 1 of each year except that rates for Hospital Intensive Neurological Rehabilitation Units, Psychiatric Hospitals, and Distinct Part Psychiatric Units are effective for services provided on or after January 1.

5. Cost Components Used in Calculating Rates

a. Fixed capital cost.

Step 1 - Peer grouping.
A single fixed capital rate cap was established for all hospitals in the five general peer groups by combining all hospitals in the five general peer groups into one array. Separate fixed capital rate caps were established for each specialty hospital peer group and each specialty unit peer group.

Step 2 - Cap calculation.
Fixed capital cost for each hospital was inflated from the midpoint of the base year to the midpoint of the implementation year (December 31,

1994), then arrayed by peer group from high to low in order to determine the median cost for the peer group. Fixed capital cost for each hospital/unit above the median was capped at the median.

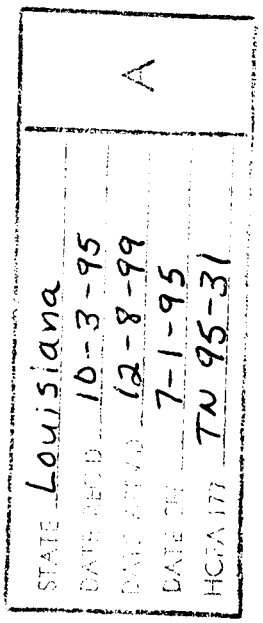
Step 3 - Calculation of blended component.
A blended component for each hospital was calculated comprised of 70% of the peer group median and 30% of the hospital-specific component (capped at the median).

Step 4 - Calculation of capped weighted average.
A capped weighted average for each peer group was calculated by multiplying the per diem cost for each hospital (capped at the median) by the number of Medicaid days provided by the hospital in 1991, adding the products, then dividing the resulting sum by the total number of Medicaid days in 1991 for all hospitals in the group.

Step 5 - Determination of hospital-specific component.
Each hospital's fixed capital cost component was set at the lower of the hospital's blended rate or the capped weighted average for the peer group.

The inflation factor is not applied annually.

b. Medical education cost.



A facility-specific cost component is allowed for any hospital that maintains a program of "Approved Educational Activities" as defined in the *Medicare Provider Reimbursement Manual* § 402.1 and listed in §404. The audit intermediary determines whether the hospital's program qualifies to have medical education costs included in each hospital's rate.

Hospitals which begin new qualifying programs are eligible to have this component included in calculation of the hospital's rate at the beginning of the state fiscal year subsequent to the hospital's valid request for medical education costs to be included, trended forward from the most recent filed cost report year to the current state fiscal year.

The component cost for each hospital that had qualifying program(s) in the hospital's base year cost report was inflated from the midpoint of the base year to the midpoint of the implementation year (December 31, 1994). Costs are inflated for each subsequent year.

c. **Movable equipment cost.** Items considered to be movable equipment are those included in the Medicare Provider Reimbursement Manual §104.4 definition of "Major Movable Equipment".

Step 1 - Peer grouping.
Separate movable equipment cost component caps were established for each general hospital peer group, specialty hospital peer group and specialty unit peer group. In the case of a group with only one hospital, the hospital specific cost is used.

Step 2 - Cap calculation.
Movable equipment cost for each hospital was inflated from the midpoint of the base year to the midpoint of the implementation year (December 31, 1994), then arrayed by peer group from high to low to determine the median cost for the peer group. Movable equipment cost for each hospital/unit above the median was capped at the median.

Step 3 - Calculation of blended component.
A blended component for each hospital was calculated comprised of 70% of the peer group median and 30% of the hospital-specific component (capped at the median).

Step 4 - Calculation of capped weighted average.
A capped weighted average for each peer group was calculated by multiplying the per diem cost for each hospital (capped at the median) by the number of Medicaid days provided by the hospital in 1991, adding the products, then dividing the resulting sum by the total number of Medicaid days in 1991 for all hospitals/units in the group.

Step 5 - Determination of hospital-specific component.
Each hospital's movable equipment cost component was set at the lower of the hospital's blended rate or the capped weighted average for the peer group.

The inflation factor is applied annually.

d. **Operating cost.**

Step 1 - Peer grouping.
Separate operating cost component caps were established for each general hospital peer group, specialty hospital peer group and specialty unit peer group. In the case of a group with only one hospital, the hospital specific cost is used.

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Step 2 - Supplementation.
Operating cost for each hospital was inflated from the midpoint of the base year to the midpoint of the implementation year (December 31, 1994), then arrayed by peer group from high to low to determine the weighted median cost for the peer group. In peer groupings with less than three facilities, the median is used. In the case of a group with only one facility, the facility-specific cost is used. For those hospitals below the weighted median, the operating cost was supplemented by 25% of the difference between the hospital-specific cost per day and the median cost per day for the peer group.

Step 3 - Cap calculation.
Operating cost for each hospital as determined in Step 2 was arrayed by peer group from high to low to determine the weighted median cost for the peer group. Operating cost for each hospital/unit above the weighted median was capped at the weighted median.

Step 4 - Calculation of blended component.
A blended component for each hospital was calculated comprised of 70% of the peer group weighted median and 30% of the hospital-specific component (as supplemented in Step 2 and capped in Step 3).

Step 5 - Calculation of capped weighted average.
A capped weighted average for each peer group was calculated by multiplying the per diem cost for each hospital (as supplemented in Step 2 and capped in Step 3) by the number of Medicaid days provided by the hospital in 1991, adding the products, then dividing the resulting sum by the total number of Medicaid days in 1991 for all hospitals/units in the group.

Step 6 - Determination of hospital-specific component.
Each hospital's operating cost component was set at the lower of the hospital's blended rate or the capped weighted average for the peer group.

The inflation factor is applied annually.

6. Calculation of Payment Rates

Individual facility rates are calculated annually by adding together the four components listed above for each facility.

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7. The following payments shall be made in addition to the prospective rate described above.

a. Nursery Boarder Infants Payments

On some occasions a newborn remains in a hospital nursery after the mother has been discharged. Reimbursement is established at the weighted median for all hospitals providing maternity care, based on 1991 cost inflated to the implementation year as described in "Inflation Factor" above, and annually thereafter.

b. Outlier Payments

In compliance with the requirement of §1902(s)(1) of the Social Security Act, additional payment shall be made for catastrophic costs associated with services provided to 1) children under age six in a disproportionate share hospital setting and 2) infants who have not attained the age of one year in any acute care setting. Each case will be reviewed on an individual basis. If covered charges exceed 200 percent of the prospective payment for the entire length of stay, payment for the entire stay will be made at cost.

Cost is defined as the hospital-specific ratio of cost to charges from the 1991 base period multiplied by the covered charges.

For new hospitals, the hospital-specific ratio of cost to charges is determined as follows:

1) For new hospitals enrolled subsequent to the 1991 base year that have completed 6 months or more of operations and have filed a cost report by Jun 30, 1994, cost data contained in the hospital's initial cost report period shall be used to determine the hospital-specific ratio of cost to charges.

2) New hospitals not having submitted a cost report of at least six months on or before June 30, 1994, will use the ratio of cost to charges of the hospital at the weighted median for the peer group.

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8. Qualifying Loss Review Process

Any hospital seeking an adjustment to the operations, movable, fixed capital, or education component of its rate shall submit a written request for administrative review within 30 days after receipt of the letter notifying the hospital of its rate. Rate notification date is considered to be five days from the date of the letter or the postmark date, whichever is later.

a. Definitions

"Qualifying loss" in this context refers to that amount by which the hospital's operating costs, movable equipment costs, fixed capital costs, or education costs (excluding disproportionate share payment adjustments) exceeds the Medicaid reimbursement for each component.

"Costs" when used in the context of operating costs, movable equipment costs, fixed capital costs, and education costs, means a hospital's costs incurred in providing covered inpatient services to Medicaid clients as allowed by the *Medicare Provider Reimbursement Manual.*

b. Permissible Basis

Consideration for qualifying loss review is available only if one of the following conditions exists:

1) rate-setting methodologies or principles of reimbursement are incorrectly applied; or

2) incorrect or incomplete data or erroneous calculations were used in the establishment of the hospital's rate; or

3) the amount allowed for a component in the hospital's prospective rate is 70 percent or less of the component cost it incurs in providing services that conform to the applicable state and federal laws of quality and safety standards.

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c. Basis Not Allowable

The following matters are not subject to a qualifying loss review:

1) the use of peer group weighted medians to establish operations component of the per diem;

2) the use of peer group medians to establish movable equipment component of the per diem;

3) the use of statewide median to establish fixed capital component of the per diem;

4) the percentages used to blend peer group and hospital-specific costs during the three year phase-in period;

5) the use of teaching and non-teaching status, specialty hospital status, and bed-size as criteria for hospital peer groups;

6) the use of Council of Teaching Hospitals full membership as criteria for major teaching status;

7) the use of fiscal year 1991 medical education costs to establish a hospital-specific medical education component;

8) the use of the DATA Resources, Inc. DRI Type Hospital Market Basket Index as the prospective escalator;

9) the decision not to escalate fixed capital beyond the implementation year;

10) the criteria used to establish the levels of neonatal intensive care;

11) the criteria used to establish the levels of pediatric intensive care;

12) the methodology used to calculate the boarder baby rates for nursery;

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